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Original Article

Breastfeeding beliefs and practices of African women living in Brisbane and Perth, Australia

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Abstract

The purpose of this study was to explore the experience of breastfeeding among refugee women from Liberia, Sierra Leone, Burundi and the Democratic Republic of Congo living in two major capital cities in Australia. Participants were recruited from their relevant community associations and via a snowballing technique. Thirty-one women took part in either individual interviews or facilitated group discussions to explore their experiences of breastfeeding in their home country and in Australia. Thematic analysis revealed four main themes: cultural breastfeeding beliefs and practices; stigma and shame around breastfeeding in public; ambivalence towards breastfeeding and breastfeeding support. Women who originated from these four African countries highlighted a significant desire for breastfeeding and an understanding that it was the best method for feeding their infants. Their breastfeeding practices in Australia were a combination of practices maintained from their countries of origin and those adopted according to Australian cultural norms. They exemplified the complexity of breastfeeding behaviour and the relationship between infant feeding with economic status and the perceived social norms of the host country. The results illustrate the need for policy makers and health professionals to take into consideration the environmental, social and cultural contexts of the women who are purportedly targeted for the promotion of breastfeeding.

Keywords: breastfeeding, breastfeeding support, cultural context, minority ethnic groups, African, Australia.

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Introduction

Breastfeeding is considered the optimal source of nutrition for infants and is recognized as a priority health area internationally (World Health Organisation 2001; Australian Health Ministers' Conference 2009; Kramer & Kakuma 2012). Breastfeeding helps to prevent gastrointestinal, chest, ear and urinary tract infections and allergies in young children, reduces the incidence of infant mortality, and decreases the risk of overweight and obesity among infants, children and adolescents (Horta *et al*. 2007). For women, breastfeeding results in decreased post-partum bleeding and increased rates of recovery from labour among mothers (Jernstrom 2004). Furthermore, the advantages of breastfeeding are dose-dependent, with exclusive breastfeeding providing greater benefits. The World Health Organization (WHO) recommends exclusive breastfeeding for the first 6 months of life and continuation to 2 years of age (World Health Organisation 2001; Kramer & Kakuma 2012). Breastfeeding is, therefore,

considered an important component in the promotion of both short- and long-term health for infants, mothers and communities.

Factors seen to influence a mother's decision to breastfeed include beliefs about breastfeeding, breastfeeding support, perception of cultural norms, economic factors and knowledge regarding infant nutrition (World Health Organisation 2001; Dennis 2002, 2006; Hector *et al*. 2004; Duong *et al*. 2005; Swanson *et al*. 2006; Baghurst *et al*. 2007; Amir & Donath 2008; Persad & Mensinger 2008; Meedya *et al*. 2010). Research identifies young, low-income, single and recent migrant mothers as being particularly vulnerable groups to poor breastfeeding outcomes (Giles *et al*. 2007). Migrant and refugee communities make up 15.8% of the Australian community (Australian Bureau of Statistics 2007). Data, however, on the initiation and duration of breastfeeding among women from migrant or refugee backgrounds are limited and contradictory, with some communities having higher rates than the rest of the Australian population and others lower (Diong *et al*. 2000; Homer *et al*. 2002; Forster *et al*. 2006; McLachlan & Forster 2006).

Recent research exploring the impact of acculturation on breastfeeding all suggest that acculturation to the host country is inversely associated with breastfeeding initiation and duration. That is, women who are more adapted to the host country have an 8–85% decrease in breastfeeding duration and initiation rates (Golin *et al*. 2003; Celi *et al*. 2005; Gorman *et al*. 2007; Harley *et al*. 2007; Singh *et al*. 2007; Kimbro *et al*. 2008; Sussner *et al*. 2008). Conversely, lower levels of acculturation to the host country are associated with up to five time greater rates of breastfeeding initiation and duration. Alternatively, suggestions have been made that rather than acculturation, breastfeeding is a locally contextual practice influenced by migration through the loss of social structures that reinforce health practices (Groleau *et al*. 2006).

While there is a small amount of research on breastfeeding beliefs and practices among women from Asian backgrounds living in Australia, little is known about those who have more recently arrived from Africa (Rossiter 1992; Rossiter & Yam 2000; Li *et al*. 2003, 2005; Utaka *et al*. 2005). Migrant and refugee women come from different traditions of child-rearing and infant feeding; among African communities, exclusive breastfeeding is rarely practised, with women being encouraged to 'mix-feed' their babies; referring to the introduction of solids or liquids other than breast milk (Kakute *et al*. 2005; Sibeko *et al*. 2005). Work in Africa also shows that grandmothers play a significant role in influencing mothers' breastfeeding practices and insufficient knowledge, combined with other cultural beliefs and practices, can result in infant feeding that does not meet international recommendations (Shirima *et al*. 2001; Kruger & Gericke 2003; Kakute *et al*. 2005; Bezner Kerr *et al*. 2008).

Breastfeeding is a complex behaviour and moving to a new country adds an additional dimension of complexity. Few studies have explored the attitudes and beliefs towards breastfeeding of refugee women as they negotiate child-rearing in their adopted nation. This study aimed to explore the experience of breastfeeding among refugee women from West Africa (Liberia, Sierra Leone) living in Brisbane,

Key messages

- Breastfeeding practices on migration are a combination of practices from countries of origin and the host country.
- Moving to a new country effectively alters the social space, removing women from support structures and cultural norms that allow women to focus on breastfeeding and mothering.
- The low visibility of breastfeeding in Australia strongly influences the perception that breastfeeding is considered a culturally shameful act.
- Public policy that acknowledges social, cultural and environmental factors combined with continued targeted support for these populations will be instrumental in maintaining and improving breastfeeding rates in migrant women and the wider community.

Queensland and from East Africa (Burundi and the Democratic Republic of Congo) living in Perth, Western Australia. This exploration will allow greater insight into the factors that influence breastfeeding decisions for refugee women and allow the tailoring of interventions to best meet their needs.

Methods

This study is a qualitative, descriptive study that employs thematic, content analysis to describe the phenomenon of breastfeeding in the target group. As indicated by Sandelowski (2000) it is the method of choice in discovering the who, what and where of events.

Data were collected from two sites: Perth, Western Australia and Brisbane, Queensland. The Perth study was completed under the auspices of the Good Food for New Arrivals project undertaken by the Association for Services to Torture and Trauma Survivors in 2007. The data collection process was scrutinized by the Steering Committee overseeing the Good Food for New Arrivals project and the community organizations. The Brisbane study was undertaken in 2008 and was approved by a Human Research Ethics Committee.

All participants had the purpose and requirements of the study explained and informed consent was gathered prior to data collection. Where appropriate a bi-cultural community worker facilitated the interviews.

Participants

Women from Burundi and the Democratic Republic of Congo in Perth, and from Liberia and Sierra Leone in Brisbane were invited to participate in the study through the women's groups of their respective community organizations. Women who agreed to participate then recommended other women for the study using a snowballing technique. Participants were mothers of all ages who have previously had children in their home country and/or Australia. There were no other inclusion or exclusion criteria. Four researchers collected the data. The researcher in Perth was assisted by a bi-cultural worker; two researchers collected data in Brisbane. In Brisbane, all participants spoke English as their first language, this being the official language in their countries of origin.

Data collection

Women participated in either an interview or a group discussion. Interviews were used as the primary source of data collection in the first stage, and were conducted in the participants' homes. The interviews aimed firstly to provide a detailed perspective on cultural beliefs, traditional practices, barriers and enablers and personal experiences in both the country of origin and Australia regarding breastfeeding. A second aim was to gauge the appropriateness and focus of the questions for the subsequent group discussions. Interviews lasted 30–90 min and were audiotaped with permission, transcribed verbatim and translated into English when required. Women from the respective communities were invited to participate in group discussions conducted in community venues using a semi-structured questioning style guided by the results of the earlier interview phases. These data were audiotaped and documented. All data were used in the analysis.

Data analysis

Interviews and facilitated discussions were thematically analysed using an inductive approach, where the identified themes were strongly linked to the data with no attempt to fit a pre-existing theoretical frame (Patton 1990). Key themes were generated using open coding, in which differences and similarities are grouped into categories for descriptive purposes. The transcripts were analysed by two researchers in each state, and reviewed and verified by another researcher. Quotes exemplifying key themes were then selected.

Results

Thirty-one participants were interviewed: three women born in Sierra Leone, eight women and one man born in Liberia, four women born in Burundi and fifteen women born in the Democratic Republic

of Congo. All participants had been repatriated to Australia on humanitarian visas and had been in Australia for between one week and 14 years with the median length of time being four years. The age of the children ranged from 2 months to 28 years, with an average age of 4 years. All women reported initiating breastfeeding with each child. A common cultural practice is to give infants water in the first week following birth; hence, the majority of infants were not exclusively breastfed. The average age for introduction of foods was around 6 months, ranging from 2 to 24 months with significant variation evident.

Based on the thematic and content analysis four central themes emerged: (1) cultural beliefs and practices; (2) stigma and shame about breastfeeding in public; (3) ambivalence towards breastfeeding; and (4) breastfeeding support. There was broad endorsement of these themes from all women.

Cultural beliefs and practices

Attitudes and beliefs towards breastfeeding were attributable to cultural tradition. Most women displayed great affection towards breastfeeding and felt that breast milk was 'natural' and better for the child than formula.

I think that breastfeeding is a great foundation for babies. My mum taught me the importance of breastfeeding cos' there's a lot of viruses going around and he never got really sick . . . Its just part of our lifestyle (Martha, Liberia).

Women also reported that traditional cultural beliefs were not always being upheld in Australia. This was for a range of reasons but predominantly due to work commitments. In addition, participants described a perceived need to adopt the Western approach which was almost always using formula.

People want to take up the western ways of doing things. They don't want anything to bother them too much. . . There are some who are in a new country, a new culture, everything, so they go along with what they have learnt here (Joyce, Sierra Leone).

In Africa I breastfeed my babies up to two years, but here I've seen people just stop breastfeeding early, they just send their babies to the child care; they are just copying the western style of living (Beth, DRC).

Yes I think there are advantages because they (formula) are manufactured by the whites; they must have known that they have advantages, and that is why they like to give their babies this other milk, it's because they know it has benefits to their babies (Sarah, Burundi).

The women reported maintaining some traditional breastfeeding practices after migration to Australia, including the consumption of 'special' foods by mothers when lactating, early introduction of liquids and solids, and water given to the baby in the first week of life. African mothers reported eating 'special foods' to stimulate the milk supply when breastfeeding including foods such as soaked peanuts, soaked rice and cassava leaves. The majority of women introduced foods or liquids other than breast milk at around 3 months of age to 'satisfy' the baby's stomach.

When the baby is hungry he's hungry and (when) breast milk is not enough for that baby . . . we have to add another something (Mary, Liberia).

After delivery I gave my baby breast milk for two months, and then I started feeding her mashed potatoes. My babies are always born with heavy weight five or six kilograms, breast milk only is not enough (Beth, DRC).

Some women reported giving water to the baby in the first week of life in the belief that it 'cleanses' the infants' intestines. On the other hand, other mothers reported that they used colostrum for this purpose. It was noted that the retention of cultural beliefs had a general positive influence on breastfeeding practices. There was some rejection of concepts thought to be too 'western', which did not necessarily fit with an African view.

After delivery women are supposed to stay indoors with the baby for a period between forty days and three months, this encourages breastfeeding, not like here once the woman delivers a baby the next two days she is already on the road because there is no support from family members (Rebecca, Burundi).

Stigma and shame about breastfeeding in public

Stigma and shame was related to several contexts regarding breastfeeding in public. Firstly, there was a sense that African women needed to conform to Australian culture by not breastfeeding in public. The women stated that the lack of visibility of public breastfeeding in Australia made the act shameful. The women, therefore, attempted to avoid this practice or would cover their breast with a cloth or towel to evade stares and scrutiny.

When I was coming (to Australia) they say it's not good to breastfeed on the street . . . I feel ashamed (Joan, Liberia).

You hardly find someone (in Australia) who breastfeeds in public . . . You are ashamed to take you breast out in public to give food. . . Whereas over there, if your child is crying, people around you are going to hit you to give a breastfeed to your baby (Celeste, Liberia).

Yes you cannot breastfeed in public, it is so embarrassed but in Africa people breastfeed everywhere nobody bothers. African women living here also feel shy to breastfeed in public (Rebecca, Burundi).

Secondly, there was also a sense of shame about being a black woman when breastfeeding in public. The women described being watched and judged by onlookers and feeling as though they were being viewed as 'primitive' for being an African women breastfeeding their child.

The way other people were looking, it's like because she's African, that's why she's doing that . . . Just the look they give you. . .Sometimes they don't have to tell you, it's just the looks (Karen, Sierra Leone).

Finally, women revealed that Australian men do not support the act of breastfeeding in public and felt that they were offended when they saw a woman breastfeed. One woman describes her feelings between African and Australian men regarding breastfeeding in public:

The (African) men know its part of our lifestyle. We have to breastfeed so when he sees a lady breastfeeding he keeps his eyes off her. She's performing her duties so he don't go watching her . . . But here it's hard; (to) some men its offensive (Karen, Sierra Leone).

The ambivalence of breastfeeding

While breastfeeding was clearly a preferential cultural practice, there was some ambivalence surrounding the practice in Africa, with women describing the reason for breastfeeding being lack of money and lack of food. A lack of money while living in Africa seemed to force a mother to breastfeed her baby, as formula milk was too expensive. Only affluent people were seen to use formula in Africa. Most women recognized breastfeeding as the better source of nutrition for the baby; however, improved finances in Australia allowed formula feeding to be an option. In addition, the lack of available food in some parts of Africa also removed any choice regarding infant feeding including the length of time to breastfeed. Coming to Australia, increased the range of choices available and meant that women were not solely reliant on breastfeeding, and foods could be introduced in response to the perceived needs of infants.

Where we are from we can't afford formula, so everyone breastfeeds . . . if you can afford formula that means you are working (Martha).

Yes, here they are more developed; they have different kinds of commercial milk and money for buying if they want to (Jane, DRC).

In Africa it was so hard. I give birth to my other babies in a refugee camp, there was no other food, and the baby relies on breast milk only. But here there is plenty of food. My baby before this one I breastfeed for four months then I give him porridge, then I stopped breastfeeding him at six months because I was pregnant (Sue, DRC).

Here food is available, and money for buying food is not a problem, even if the baby doesn't take to breast milk you can introduce other milk and food without any problem but in Africa getting food is a problem. The only place to get milk for the baby is from the mother's breast (Bridget, Burundi).

In refugee camps we gave our babies breast milk not because of its importance but because it was the only one

that is available, so people coming here to Australia and having a choice must be for the better (Ruth, DRC).

The family finances have an impact on the types of foods introduced to the infant. Mothers stated that in Africa, the types of foods introduced to the baby were dependent upon affordability. The age of introduction of meat was particularly reliant upon finances, but following migration to Australia and enhanced financial security, the introduction of meat was more likely to be determined by the baby having sufficient teeth to chew. Improved finances of African migrants in Australia has also seen the adoption of the use canned baby food bought in the supermarket, compared with traditional foods such as banana, rice and sauce or sesame seed porridge.

Breastfeeding support

Women described a range of barriers to breastfeeding within the Australian context. The primary difference was the loss of family support; women expressed the importance of their mothers and aunties as a major source of support and missed their presence in Australia. One woman reported the traditional practice of living with the mother for the first one or two years of the baby's life, in order to assist in breastfeeding and preparation of the baby's food. Many women have migrated to Australia without their mothers; therefore, this practice was not possible for most women. Nonetheless, these women still turn to female friends and family for support.

Mums and aunties and grandmothers (help us) . . . our extended family. We have friends so we considered them to be our family (Margaret, Sierra Leone).

Nobody helps me here, but if I was in Africa, I could call my mother, sisters, even my neighbours, to help me taking care of the my house works and other kids. But here in Australia, I'm in the house for months and I don't know even my next house person (Carmel, DRC).

Women also reported their male partners were important support networks. Traditional practices in Africa involve sexual abstinence for the first year of breastfeeding, although women state this practice is not as common as it used to be. Women expressed the importance of men as a source of encouragement, support and assistance by recognizing breastfeeding as part of the mother's 'job'. However, they also pointed out that they did not expect African men to assist with more tangible assistance in the household.

They also tell us that there should be no relations with your man until the baby is one year old. This means you concentrate on the baby and don't lose your milk. If you have a good man they will do that, encourage you. If you have a bad man, they want you to stop early (Gabrielle, Liberia).

Maybe if you are married with white men (they might help), the African men they don't have that culture of helping their wife with the house works (Carmel, DRC).

Many women in Africa received breastfeeding advice from health services, provided in antenatal and postnatal clinics. A few participants described the practice of attending group clinics in Africa, which allowed women to share their experiences, learn from each other's problems and develop a support network. In Australia the primary barriers were associated with language barriers.

They wanted to tell me about feeding my baby but they send me a person who speaks English, I don't understand English (Catherine, DRC).

Discussion

Given that infant feeding choices are embedded in the context of ethnic and cultural beliefs, it is important to understand how these may be influenced when moving to a new country (Kannan *et al.* 1999; Zareai *et al.* 2007). Previous research on migrants moving from less to more affluent countries has described a relatively simple relationship between acculturation and breastfeeding. Women who become more acculturated to the host country tend to breastfeed less (Gorman *et al.* 2007; Harley *et al.* 2007; Sussner *et al.* 2008). This research, however, indicates a more complex relationship with social norms influenced by a range of temporal and local contexts.

There are indications that breastfeeding initiation and duration rates are higher in countries within the African continent (Dettwyler 1986; Davies-Adetugbo

1997; Kakute *et al*. 2005) and are in some cases, higher among women in emergency situations such as refugee camps than those in Australia (Lung'aho *et al*. 1996). However, limited data from these countries of origin and in refugee situations, paint a more complex picture with exclusive breastfeeding rates in Liberia for infants at 6 months being 29% and in Burundi 45% (United Nations Children's Fund 2010). The participants in this study, however, indicated that rates of feeding with formula increased with affluence. There were also indications that one of the reasons for breastfeeding exclusivity was the lack of available food, when food was available, it was introduced early in response to the perceived needs of the infant. This gives some indication that formula feeding is a sign of cultural capital. When an item, such as infant formula, is used as one of the key markers of class, its consumption can correlate with an individual's 'fit' in society (Bourdieu 1984). It follows therefore, that even if breastfeeding is known to be the biological and cultural norm, a change in circumstances will result in a change in the balance between breast and bottle.

Although women in this study seemed to retain traditional values related to breastfeeding, it was evident that some barriers existed, including shame about breastfeeding in public, return to or entry into the paid workforce, loss of support networks, and the lack of appropriate support and materials in their language of choice. These barriers have only transpired as women compare their cultural understandings and experiences between countries and acknowledge and try to adopt these underlying values in their adopted home. In other words, the process of acculturation has highlighted the variance and women either retain or reject their cultural practices. Therefore, in testing the impact of acculturation on breastfeeding, care needs to be taken in interpreting practices.

Support networks from family and friends were obviously highly valued by these Liberian, Sierra Leonean, Burundian and Congolese women, and there was a clear role played by fathers and men within the community. Moving to Australia had effectively altered the social space, removing not only the individuals themselves, but also the social infrastructure and cultural norms that allowed women to focus on breastfeeding and mothering (Groleau *et al*. 2006). Loss of this support and the pressure to return to paid work are well documented as barriers to breastfeeding for all women (Pontes *et al*. 2009; Wambach & Cohen 2009; Mandal *et al*. 2010; Twamley *et al*. 2011).

Infant feeding beliefs and attitudes in Australia are seen to support the notion that overt displays of breastfeeding in public are not considered socially acceptable, and there is a general consensus that the culturally approved age that children should be weaned is around 12 months (Scott *et al*. 1997; Scott & Mostyn 2003). Creating a supportive environment where breastfeeding in public is an acceptable social practice would appear to be instrumental in ensuring that women have 'permission' to breastfeed. The low visibility of breastfeeding in public domains creates a perception that it is an unacceptable practice. The spaces provided by group clinics and the influence of kith and kin on successfully initiating and maintaining breastfeeding in their home countries is something that needs to be replicated in Australia (Bailey & Pain 2001).

Although there are a multitude of programmes and interventions across numerous areas of breastfeeding promotion, there is a lack of integration among national, state and local governments, health-provider organizations, self-help and support groups, and community programmes. The low visibility of breastfeeding in Australia strongly influenced the perception that in Australia, breastfeeding is considered a culturally shameful act. This perception makes the decision to initiate breastfeeding and to breastfeed beyond 12 months more difficult. The lack of culturally sensitive social and professional support available in the language of choice points to a failure by authorities to ensure equitable access to health services.

The WHO recommends exclusive breastfeeding to 6 months of age and continued breastfeeding for at least 2 years (World Health Organisation 2001; Butte *et al*. 2002). Despite the fact that extensive research has increased our knowledge of the benefits of breast milk for the infant, the mother's choice of infant feeding method is often socially and culturally mediated (Smith 2007). The current, ongoing focus on shifting the onus of responsibility for failing to breastfeed to the individual fails to take into consideration

the social and cultural context. These women from various African countries have articulated the maintenance of a high level of engagement with, and understanding of, breastfeeding practices that are dependent on a favourable social space. The onus is now on Australia to develop and implement an environment that despite the shifting complexities of cultural and social values, encourages and supports women to breastfeed.

Strengths and limitations

Very few studies look at the changes in attitudes of refugee women to breastfeeding as they settle in a new country. The qualitative methodology was one of the strengths of the study allowing women, in their own words, to articulate their feelings and attitudes towards breastfeeding. A limitation is the different methodologies used in the collection of data. Women in the group setting may not have had the same opportunities to articulate their views.

Conclusion

This study has demonstrated that women from African communities in Brisbane and Perth, Australia have combined traditional breastfeeding beliefs and practices with those routinely practised in Australia. Their responses highlight the complexity of breastfeeding behaviour and the interplay of cultural and social beliefs, practices and spaces. Public policy that acknowledges social, cultural and environmental factors combined with the routine collection of data and continued support for these populations will be instrumental in maintaining and improving breastfeeding rates in migrant women and the wider community.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

Contributions

All co-authors collected, analysed and undertook interpretations of data. DG and SS wrote the preliminary manuscript with DG finalizing the manuscript. All co-authors critically reviewed sections of the manuscript.

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